		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 S. Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

IDPA ID Number: 363635151001

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,780	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,589	3,457	4,302	28,348	8
9	SNF/PED					9
10	ICF	14,551	3,026	956	18,533	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,140	6,483	5,258	46,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.68%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 4,199

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	284,440	24,641	9,288	318,369		318,369		318,369			1
2	Food Purchase		190,539		190,539		190,539	(9,163)	181,376			2
3	Housekeeping	290,767	33,573		324,340		324,340		324,340			3
4	Laundry	21,059	21,333		42,392		42,392	(4,846)	37,546			4
5	Heat and Other Utilities			183,743	183,743		183,743	2,456	186,199			5
6	Maintenance	49,749		108,046	157,795		157,795	6,284	164,079			6
7	Other (specify):*											7
8	**TOTAL General Services**	646,015	270,086	301,077	1,217,178		1,217,178	(5,269)	1,211,909			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,054,358	170,489	398,798	2,623,645		2,623,645		2,623,645			10
10a	Therapy			472,734	472,734		472,734		472,734			10a
11	Activities	133,483	21,249	2,491	157,223		157,223		157,223			11
12	Social Services	61,903		2,475	64,378		64,378		64,378			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,249,744	191,738	888,498	3,329,980		3,329,980		3,329,980			16
	C. General Administration											
17	Administrative	148,063		260,702	408,765		408,765	(260,702)	148,063			17
18	Directors Fees											18
19	Professional Services			69,027	69,027		69,027	866	69,893			19
20	Dues, Fees, Subscriptions & Promotions			27,247	27,247		27,247	2,252	29,499			20
21	Clerical & General Office Expenses	334,066	37,975	24,598	396,639		396,639	12,449	409,088			21
22	Employee Benefits & Payroll Taxes			394,723	394,723		394,723	45,011	439,734			22
23	Inservice Training & Education			12	12		12		12			23
24	Travel and Seminar			4,413	4,413		4,413	1,284	5,697			24
25	Other Admin. Staff Transportation			38	38		38	7,427	7,465			25
26	Insurance-Prop.Liab.Malpractice			85,806	85,806		85,806	1,829	87,635			26
27	Other (specify):*											27
28	**TOTAL General Administration**	482,129	37,975	866,566	1,386,670		1,386,670	(189,584)	1,197,086			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,377,888	499,799	2,056,141	5,933,828		5,933,828	(194,853)	5,738,975			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale #0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			55,951	55,951		55,951	173,088	229,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,000	8,000		8,000	335,095	343,095			32
33	Real Estate Taxes							117,699	117,699			33
34	Rent-Facility & Grounds			1,076,302	1,076,302		1,076,302	(1,076,302)				34
35	Rent-Equipment & Vehicles							505	505			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,140,253	1,140,253		1,140,253	(449,915)	690,338			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,283	21,449	108,732		108,732		108,732			39
40	Barber and Beauty Shops			12,501	12,501		12,501		12,501			40
41	Coffee and Gift Shops			1,454	1,454		1,454		1,454			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* Nonallowable costs			(1,796)	(1,796)		(1,796)	1,796				43
44	**TOTAL Special Cost Centers**		87,283	127,778	215,061		215,061	1,796	216,857			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,377,888	587,082	3,324,172	7,289,142		7,289,142	(642,972)	6,646,170			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,846)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,727)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(681)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(910)	43		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,457)	43		24
25	Fund Raising, Advertising and Promotional	(7,632)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	9,145	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(6,184)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,400)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(622,572)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (622,572)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (642,972)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington Health Care Center-Bloomingdale

ID# 0035188

Report Period Beginning: 01/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/01 - 12/31/01 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(3,709)	19
Out of period legal fees	(1,131)	19
Disallow Chamber of Commerce Dues	(275)	20
Offset miscellaneous income	(6,536)	21
Deferred maintenance amortization	5,467	6
Total	(6,184)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8)	0	0	0	0	0	0	0	0	0	0	(8)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,846)	0	0	0	0	0	0	0	0	0	0	(4,846)	4
5	Heat and Other Utilities	0	0	2,456	0	0	0	0	0	0	0	0	2,456	5
6	Maintenance	0	0	817	0	0	0	0	0	0	0	0	817	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,854)	0	3,273	0	0	0	0	0	0	0	0	(1,581)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(260,702)	0	0	0	0	0	0	0	(260,702)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18	5,688	0	0	0	0	0	0	0	0	5,706	19
20	Fees, Subscriptions & Promotions	0	0	2,527	0	0	0	0	0	0	0	0	2,527	20
21	Clerical & General Office Expenses	0	2,553	16,432	0	0	0	0	0	0	0	0	18,985	21
22	Employee Benefits & Payroll Taxes	0	0	35,856	0	0	0	0	0	0	0	0	35,856	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,284	0	0	0	0	0	0	0	0	1,284	24
25	Other Admin. Staff Transportation	0	0	7,427	0	0	0	0	0	0	0	0	7,427	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,829	0	0	0	0	0	0	0	1,829	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	2,571	69,214	(258,873)	0	0	0	0	0	0	0	(187,088)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,854)	2,571	72,487	(258,873)	0	0	0	0	0	0	0	(188,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 01/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	163,013	0	10,075	0	0	0	0	0	0	0	173,088	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,727)	341,833	0	989	0	0	0	0	0	0	0	335,095	32
33	Real Estate Taxes	0	116,303	0	1,396	0	0	0	0	0	0	0	117,699	33
34	Rent-Facility & Grounds	0	(1,076,302)	0	0	0	0	0	0	0	0	0	(1,076,302)	34
35	Rent-Equipment & Vehicles	0	0	0	505	0	0	0	0	0	0	0	505	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,727)	(455,153)	0	12,965	0	0	0	0	0	0	0	(449,915)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,635)	3,431	0	0	0	0	0	0	0	0	0	1,796	43
44	**TOTAL Special Cost Centers**	(1,635)	3,431	0	0	0	0	0	0	0	0	0	1,796	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,216)	(449,151)	72,487	(245,908)	0	0	0	0	0	0	0	(636,788)	45

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	22.33%			Sambell of Bloomingdale		
John Samatas	22.33%	See attached Schedule B		Limited Partnership	Bloomingdale	Real estate ptsp.
Cynthia Thiem	22.34%			Royal Mgmt. Corp	Lombard	Mgmt. Co.
Jeffrey J. Bell Revocable Trust	8.25%			Lexington Financial		
Lawrence W. Bell Declaration of Trust	8.25%			Services, L.L.C.	Lombard	Finance Co.
David S. Bell Declaration of Trust	8.25%					
Dorothy D. Bell Declaration of Trust	8.25%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,076,302	Sambell of Bloomingdale Limited Partnership	**	$	$ (1,076,302)	1
2	V	19	Professional fees		Sambell of Bloomingdale Limited Partnership	**	18	18	2
3	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**	145	145	3
4	V	21	Administrative expenses		Sambell of Bloomingdale Limited Partnership	**	2,408	2,408	4
5	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	163,013	163,013	5
6	V	32	Interest expense		Sambell of Bloomingdale Limited Partnership	**	337,404	337,404	6
7	V	32	Amortization of mortgage costs		Sambell of Bloomingdale Limited Partnership	**	4,429	4,429	7
8	V	33	Property taxes		Sambell of Bloomingdale Limited Partnership	**	116,303	116,303	8
9	V	43	State replacement tax		Sambell of Bloomingdale Limited Partnership	**	3,431	3,431	9
10	V								10
11	V				** The owners of Lexington Health Care Center of Bloomingdale, Inc. own 100%				11
12	V				of Sambell of Bloomingdale Limited Partnership				12
13	V								13
14	Total			$ 1,076,302			$ 627,151	$ * (449,151)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188 **Schedule B**
1/1/01 - 12/31/01

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities - gas & electric	$	Royal Management Corp.	**	$ 2,172	$ 2,172	15
16	V	5	Utilities - water & sewer		Royal Management Corp.	**	284	284	16
17	V	6	Repairs & maintenance		Royal Management Corp.	**	569	569	17
18	V	6	Scavenger & exterminating		Royal Management Corp.	**	238	238	18
19	V	6	Security service		Royal Management Corp.	**	10	10	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	4,349	4,349	20
21	V	19	Professional fees		Royal Management Corp.	**	1,339	1,339	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	2,068	2,068	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	459	459	23
24	V	21	Bank charges		Royal Management Corp.	**	2,477	2,477	24
25	V	21	Communications		Royal Management Corp.	**	448	448	25
26	V	21	Office supplies & printing		Royal Management Corp.	**	5,344	5,344	26
27	V	21	Postage		Royal Management Corp.	**	2,257	2,257	27
28	V	21	Telephone		Royal Management Corp.	**	5,906	5,906	28
29	V	22	FICA		Royal Management Corp.	**	21,996	21,996	29
30	V	22	FUTA		Royal Management Corp.	**	454	454	30
31	V	22	SUTA		Royal Management Corp.	**	860	860	31
32	V	22	Insurance - W/C		Royal Management Corp.	**	277	277	32
33	V	22	Insurance - Hospitalization		Royal Management Corp.	**	9,185	9,185	33
34	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	3,084	3,084	34
35	V	24	Travel & seminar		Royal Management Corp.	**	1,284	1,284	35
36	V	25	Auto expense		Royal Management Corp.	**	7,427	7,427	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 72,487	$ * 72,487	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - general	$	Royal Management Corp.	**	$ 1,829	$ 1,829	15
16	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,092	3,092	16
17	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	1,903	1,903	17
18	V	30	Depreciation - equipment		Royal Management Corp.	**	5,080	5,080	18
19	V	32	Interest		Royal Management Corp.	**	989	989	19
20	V	33	Property taxes		Royal Management Corp.	**	1,396	1,396	20
21	V	35	Equipment rental		Royal Management Corp.	**	505	505	21
22	V	17	Management	260,702	Royal Management Corp.	**		(260,702)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 260,702			$ 14,794	$ * (245,908)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdal # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	9.00%	Salary	$ 30,961	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10.00%	Salary	13,615	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10.00%	Salary	17,085	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10.00%	Salary	6,975	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2	4.00%	Salary	9,414	L17, C1	5
6											6
7											7
8					All individuals worked in excess of 40 hour per week						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 78,050		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center-Bloomingdale
Provider # 0035188 **Schedule C**
1/1/01 - 12/31/01

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	149,410	339,756	187,478	76,542	103,303	856,489

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	$ 26,007	$	62,780	$ 2,172	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397		62,780	284	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818		62,780	569	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851		62,780	238	4
5	6	Security Service	Bed Days	751,703	11	125		62,780	10	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068		62,780	4,349	6
7	19	Professional fees	Bed Days	751,703	11	16,027		62,780	1,339	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766		62,780	2,068	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496		62,780	459	9
10	21	Bank charges	Bed Days	751,703	11	29,664		62,780	2,477	10
11	21	Communications	Bed Days	751,703	11	5,359		62,780	448	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988		62,780	5,344	12
13	21	Postage	Bed Days	751,703	11	27,021		62,780	2,257	13
14	21	Telephone	Bed Days	751,703	11	70,716		62,780	5,906	14
15	22	FICA	Bed Days	751,703	11	263,374		62,780	21,996	15
16	22	FUTA	Bed Days	751,703	11	5,433		62,780	454	16
17	22	SUTA	Bed Days	751,703	11	10,292		62,780	860	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319		62,780	277	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982		62,780	9,185	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931		62,780	3,084	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373		62,780	1,284	21
22	25	Auto expense	Bed Days	751,703	11	88,927		62,780	7,427	22
23										23
24										24
25	TOTALS					$ 867,934	$		$ 72,487	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance - general	Bed Days	751,703	11	$ 21,896	$	62,780	$ 1,829	1
2	30	Depreciation - vehicles	Bed Days	751,703	11	37,022		62,780	3,092	2
3	30	Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		62,780	1,903	3
4	30	Depreciation - equipment	Bed Days	751,703	11	60,826		62,780	5,080	4
5	32	Interest	Bed Days	751,703	11	11,844		62,780	989	5
6	33	Property taxes	Bed Days	751,703	11	16,719		62,780	1,396	6
7	35	Equipment rental	Bed Days	751,703	11	6,049		62,780	505	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 177,145	$		$ 14,794	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	x		Mortgage	Varies	2/1/96	5,575,000	4,839,168	02/06/2026	Variable	337,404	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	x		Working Capital	None	Various	744,845	143,945	Demand	0.0500	8,000	6
7												7
8												8
9	TOTAL Facility Related						$ 6,319,845	$ 4,983,113			$ 345,404	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,429	10
11								Interest Income offset			(7,727)	11
12								Management company allocation			989	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,309)	14
15	TOTALS (line 9+line14)						$ 6,319,845	$ 4,983,113			$ 343,095	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 120,000	1
Allocated from management company		1,396	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 116,303	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,301)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 120,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 117,699	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	107,346	8
	1997	112,356	9
	1998	114,528	10
	1999	114,820	11
	2000	116,303	12

2000 tax:	116,303
Estimated increase:	1.04
Estimated 2001 taxes:	120,372
Use:	120,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingdale COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-401-003	Land and building	$ 116,301.86	$ 116,301.86
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 68,214.22	$ 1,396.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 184,516.08	$ 117,697.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2					2
3	TOTALS	43,000		$ 402,548	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 1,079,099	4
5	9		1992	1992	178,974		35	5,114	5,114	51,137	5
6	75		1994	1994	2,022,894		35	57,797	57,797	433,477	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586	128	10	128		2,586	11
12	Building Improvements			1992	3,154	315	10	315		2,997	12
13	Building Improvements			1993	1,582	158	10	158		1,344	13
14	Building Improvements			1994	15,734	1,573	10	1,573		11,801	14
15	Land Improvements			1994	1,381	138	10	138		1,036	15
16	Land Improvements			1995	1,074		15	72	72	465	16
17	Building Improvements			1995	1,288		35	37	37	256	17
18	Building Improvements			1995	9,433	270	35	270		1,755	18
19	Building Improvements			1995	43,839	1,252	35	1,252		8,138	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706	298	10-35	298		1,640	21
22	Land Improvements - drain tile system			1996	7,858		15	524	524	2,881	22
23	Resident room heaters			1997	3,563	102	35	102		509	23
24	Automatic doors			1997	12,950	370	35	370		1,511	24
25	Basement renovation			1997	58,806	5,936	10	5,936		24,732	25
26	Land Improvement - outdoor flagpoles			1997	1,574	105	15	105		472	26
27	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487	7,649	10	7,649		26,771	27
28	Wiring for MDS			1998	4,506	451	10	451		1,577	28
29	Flag Pole			1998	787	79	10	79		275	29
30	Resurface/Stripe Parking Lot			1998	9,777	978	10	978		3,422	30
31	Kitchen tile/paint			1999	718	72	10	72		180	31
32	1st Floor Remodel			1999	3,296	330	10	330		989	32
33	Roof repairs			2000	5,748	383	15	383		575	33
34	Sump pump			2000	2,534	253	10	253		380	34
35	Sump pump basin repair			2000	6,306	631	10	631		946	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic door closers	2000	$ 1,300	$ 87	15	$ 87	$	$ 130	37
38	Parking lot seal and restripe	2001	2,473	124	10	124		124	38
39	Infrared curtains for elevator doors	2001	3,000	150	10	150		150	39
40									40
41									41
42									42
43	Allocated from management company	1995	8,387			260	260	1,558	43
44	Allocated from management company	1996	6,826			211	211	1,073	44
45	Allocated from management company	1989	235			7	7	103	45
46	Allocated from management company - HVAC	1998	177			5	5	20	46
47	Allocated from management company - Offices	1999	446			14	14	32	47
48	Allocated from management company - Offices	2000	212			7	7	11	48
49	Allocated from management company	1987	43,159			1,336	1,336	18,901	49
50	Allocated from management company	1993	23			1	1	5	50
51	Allocated from management company	1995	972			30	30	161	51
52	Allocated from management company	1996	195			6	6	26	52
53	Allocated from management company - Sidewalk	1998	407			13	13	35	53
54	Allocated from management company - Roof	1998	15			1	1	5	54
55	Allocated from management company - Awnings	1999	115			3	3	8	55
56	Allocated from management company - Parking lot	1999	251			8	8	58	56
57	Allocated from management company - Facade	2001	36			1	1	1	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,547,401	$ 21,832		$ 172,471	$ 150,639	$ 1,696,106	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 413,629	$ 31,335	$ 45,612	$ 14,277	5-10 years	$ 211,422	71
72	Current Year Purchases	19,185	2,784	2,784		5-10 years	2,784	72
73	Fully Depreciated Assets	263,494					263,494	73
74	Allocated from Mgmt. Co.	54,876		5,080	5,080		39,873	74
75	TOTALS	$ 751,184	$ 34,119	$ 53,476	$ 19,357		$ 517,573	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			24,841		3,092	3,092		16,183	79
80	TOTALS			$ 24,841	$	$ 3,092	$ 3,092		$ 16,183	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,725,974	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,951	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,039	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 173,088	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,229,862	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 505 Description: Allocated from management company: $505
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	17,158	$ 187,317	$	17,158	$ 187,317	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,940	35,779		1,940	35,779	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,055	249,638		16,055	249,638	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				87,283		87,283	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					21,449			21,449	13
14	TOTAL			$	35,153	$ 494,183	$ 87,283	35,153	$ 581,466	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/01 - 12/31/01 **Schedule D**

XIV. Special Services (Direct Cost)
Line 13, Other

Service	Cost	Line Reference
Oxygen	14,126	L 39, C3
Laboratory	1,531	L 39, C3
Radiology	2,707	L 39, C3
Dentist	1,635	L 39, C3
Clinitron beds	1,450	L 39, C3
Total	21,449	

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (61,248)	$ (34,678)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 195,582)	1,696,474	1,696,474	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,270	28,270	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,358	7,363	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,673,854	$ 1,697,429	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	105,324	105,324	12
13	Land		402,548	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	283,914	364,670	15
16	Equipment, at Historical Cost	332,737	776,025	16
17	Accumulated Depreciation (book methods)	(247,967)	(2,229,862)	17
18	Deferred Charges		4,511	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Loan Costs		91,296	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 474,008	$ 4,697,243	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,147,862	$ 6,394,672	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,542	$ 228,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	143,945	143,945	29
30	Accrued Salaries Payable	81,389	81,389	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,921	2,921	31
32	Accrued Real Estate Taxes(Sch.IX-B)		120,000	32
33	Accrued Interest Payable		40,245	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	469,852	202,004	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 926,649	$ 819,046	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,839,168	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,839,168	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 926,649	$ 5,658,214	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,221,213	$ 736,458	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,147,862	$ 6,394,672	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/01 - 12/31/01 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	267,848	-
Accrued management fees	110,003	110,003
Accrued 401 (k) contribution	6,464	6,464
401 (k) withholding	2,049	2,049
P/A audit settlement	45,545	45,545
Other accrued expenses	37,943	37,943
Total line 36	469,852	202,004

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous income	6,536
Investment income in Lexington Financial Services, L.L.C	3,112
Total line 28	9,648

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,115,012	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,115,012	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	106,201	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 106,201	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,221,213	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,634,504	1
2	Discounts and Allowances for all Levels	(282,006)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,352,498	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	780,076	6
7	Oxygen	3,880	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 783,956	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,384	12
13	Barber and Beauty Care	15,689	13
14	Non-Patient Meals	8	14
15	Telephone, Television and Radio	40	15
16	Rental of Facility Space		16
17	Sale of Drugs	109,203	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,935	19
20	Radiology and X-Ray	2,806	20
21	Other Medical Services	96,603	21
22	Laundry	4,846	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 241,514	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,727	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,727	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	9,648	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,648	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,395,343	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,217,178	31
32	Health Care	3,329,980	32
33	General Administration	1,386,670	33
	B. Capital Expense		
34	Ownership	1,140,253	34
	C. Ancillary Expense		
35	Special Cost Centers	120,891	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,289,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	106,201	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 106,201	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,005	$ 74,757	$ 37.29	1
2	Assistant Director of Nursing	1,993	2,094	51,761	24.72	2
3	Registered Nurses	34,547	36,057	867,015	24.05	3
4	Licensed Practical Nurses	6,336	6,636	130,732	19.70	4
5	Nurse Aides & Orderlies	76,528	78,276	810,350	10.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,996	9,440	119,743	12.68	8
9	Activity Director	2,318	2,458	27,681	11.26	9
10	Activity Assistants	11,414	10,597	105,802	9.98	10
11	Social Service Workers	3,639	3,674	61,903	16.85	11
12	Dietician	87	93	2,586	27.81	12
13	Food Service Supervisor	2,517	2,615	38,611	14.77	13
14	Head Cook	1,809	1,970	23,805	12.08	14
15	Cook Helpers/Assistants	16,194	16,898	136,236	8.06	15
16	Dishwashers	13,378	13,779	83,202	6.04	16
17	Maintenance Workers	3,340	3,568	49,749	13.94	17
18	Housekeepers	41,629	43,738	290,767	6.65	18
19	Laundry	3,510	3,510	21,059	6.00	19
20	Administrator	2,364	2,439	70,013	28.71	20
21	Assistant Administrator					21
22	Other Administrative	558	572	78,050	136.45	22
23	Office Manager					23
24	Clerical	19,624	20,923	334,066	15.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	252,749	261,342	$ 3,377,888 *	$ 12.93	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,288	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant	25	1,225	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,491	L11, C3	44
45	Social Service Consultant	Monthly	2,475	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	$ 28,679		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	15,958	$ 316,220	L10, C3	50
51	Licensed Practical Nurses	3,138	53,347	L10, C3	51
52	Nurse Aides	1,675	26,806	L10, C3	52
53	TOTAL (lines 50 - 52)	20,771	$ 396,373		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See attached Schedule F			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	260,702
TOTAL (agree to Schedule V, line 17, col. 3)	$ 260,702
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity Co.	401(k) Administration	$ 285
Altschuler, Melvoin & Glasser	Accounting	17,300
American Express Tax & Bus. Svcs.	Accounting	6,940
American Recruiters	Recruitment	17,500
Environetx	Space Consulting	242
Robert Stachura	Accounting	27
James Samatas	Legal	129
Personnel Planners	U/C Consulting	1,240
Royal Management	Website Development	369
Sachnoff & Weaver	Legal	9,436
Systematic Management	Billing Consulting	7,308
See attached Schedule F		8,251
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 69,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,525
Unemployment Compensation Insurance	23,340
FICA Taxes	250,585
Employee Health Insurance	55,833
Employee Meals	9,155
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	8,430
CNA Transportation	38,448
Other employee benefits	18,418
TOTAL (agree to Schedule V, line 22, col.8)	$ 439,734

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	24,534
Health Care Worker Background Check	
(Indicate # of checks performed 74)	888
Miscellaneous Permits & Fees	765
Miscellaneous Dues & Subscriptions	585
Allocated from management company	2,527
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,499

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,413
Allocated from management company	1,284
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,697

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/01 - 12/31/01

Schedule F

XIX. Support Schedules

A. Administrative Salaries

Name	Function	Ownership	Amount
Robert Van Rhee	Administrator	0%	10,635
Kimberly Goodal	Administrator	0%	36,625
Esther Davis	Administrator	0%	22,753
John Samatas	Admin/Plant Ops	22.33%	13,615
James Samatas	Administrative	22.33%	30,961
Cynthia Thiem	Administrative	22.34%	17,085
George Samatas	Administrative	0%	6,975
Jason Samatas	Administrative	0%	9,414
		Total	148,063

C. Professional Services

Vendor/Payee		
Advanced Information M	Computer Consulting	2,624
Information Controls In	Computer Consulting	929
Answers On Demand	Computer Consulting	413
Global Care	IOC Consulting	576
Freidman, Anselmo & L	Collections	3,709
		8,251
Total, Agrees to Schedule V, Line 19, Column 3		69,027
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express T	Accounting	866
James Samatas	Legal	3
BDO Seidman, LLP	Accounting	13
Sachnoff & Weaver	Legal	43
Robert Stachura	Accounting	2
Pension Administrators	401 (k) Administration	183
Various	Consulting	229
Various	Computer Services	4,349
Allocated from building partnership		
James Samatas	Annual report	18
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg		(3,709)
Sachnoff & Weaver		(1,131)
Total, Agrees to Schedule V, Line 19, Column 8		69,893

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred Maintenance	Various, 1998	$ 7,698	3	$ 1,283	$ 2,566	$ 2,566	$ 1,283	$	$	$	$	$
2	Painting & Decorating	2/1998	1,660	3	277	553	553	277					
3	Deferred Maintenance	2/1999	4,043	3		674	1,348	1,348	673				
4	Painting & Decorating	Various, 2000	7,676	3			1,279	2,559	2,559	1,279			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 21,077		$ 1,560	$ 3,793	$ 5,746	$ 5,467	$ 3,232	$ 1,279	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **79,085** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **94,170**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,155** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	284,440	24,641	9,288	318,369	0	318,369	0	318,369
2. Food Pr	0	190,539	0	190,539	0	190,539	-9,163	181,376
3. Housek	290,767	33,573	0	324,340	0	324,340	0	324,340
4. Laundry	21,059	21,333	0	42,392	0	42,392	-4,846	37,546
5. Heat an	0	0	183,743	183,743	0	183,743	2,456	186,199
6. Mainten	49,749	0	108,046	157,795	0	157,795	6,284	164,079
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	646,015	270,086	301,077	1,217,178	0	1,217,178	-5,269	1,211,909
9. Medical	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursin	2,054,358	170,489	398,798	2,623,645	0	2,623,645	0	2,623,645
10a. Thera	0	0	472,734	472,734	0	472,734	0	472,734
11. Activiti	133,483	21,249	2,491	157,223	0	157,223	0	157,223
12. Social	61,903	0	2,475	64,378	0	64,378	0	64,378
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,249,744	191,738	888,498	3,329,980	0	3,329,980	0	3,329,980
17. Admin	148,063	0	260,702	408,765	0	408,765	-260,702	148,063
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	69,027	69,027	0	69,027	866	69,893
20. Fees,	0	0	27,247	27,247	0	27,247	2,252	29,499
21. Clerica	334,066	37,975	24,598	396,639	0	396,639	12,449	409,088
22. Emplo	0	0	394,723	394,723	0	394,723	45,011	439,734
23. Inservi	0	0	12	12	0	12	0	12
24. Travel	0	0	4,413	4,413	0	4,413	1,284	5,697
25. Other	0	0	38	38	0	38	7,427	7,465
26. Insura	0	0	85,806	85,806	0	85,806	1,829	87,635
27. Other	0	0	0	0	0	0	0	0
28. Total G	482,129	37,975	866,566	1,386,670	0	1,386,670	-189,584	1,197,086
29. Total G	3,377,888	499,799	2,056,141	5,933,828	0	5,933,828	-194,853	5,738,975
30. Depre	0	0	55,951	55,951	0	55,951	173,088	229,039
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	8,000	8,000	0	8,000	335,095	343,095
33. Real E	0	0	0	0	0	0	117,699	117,699
34. Rent -	0	0	1,076,302	1,076,302	0	1,076,302	########	0
35. Rent -	0	0	0	0	0	0	505	505
36. Other	0	0	0	0	0	0	0	0
37. Total G	0	0	1,140,253	1,140,253	0	1,140,253	-449,915	690,338
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	87,283	21,449	108,732	0	108,732	0	108,732
40. Barber	0	0	12,501	12,501	0	12,501	0	12,501
41. Coffee	0	0	1,454	1,454	0	1,454	0	1,454
42. Provid	0	0	94,170	94,170	0	94,170	0	94,170
43. Other	0	0	-1,796	-1,796	0	-1,796	1,796	0
44. Total S	0	87,283	127,778	215,061	0	215,061	1,796	216,857
45. Grand	3,377,888	587,082	3,324,172	7,289,142	0	7,289,142	-642,972	6,646,170

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	-61,248	-34,678
2. Cash - F	0	0
3. Account	1,696,474	1,696,474
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	28,270	28,270
7. Other Pr	0	0
8. Account	10,358	7,363
9. Other (s	0	0
10. Total cı	1,673,854	1,697,429
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	105,324	105,324
13. Land	0	402,548
14. Buildin	0	5,182,731
15. Leaseh	283,914	364,670
16. Equipm	332,737	776,025
17. Accum	-247,967	########
18. Deferre	0	4,511
19. Organi:	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	0	91,296
24. Total L	474,008	4,697,243
25. Total A	2,147,862	6,394,672
CURRENT LIABILITIES		
26. Accour	228,542	228,542
27. Officer'	0	0
28. Accour	0	0
29. Short-T	143,945	143,945
30. Accrue	81,389	81,389
31. Accrue	2,921	2,921
32. Accrue	0	120,000
33. Accrue	0	40,245
34. Deferre	0	0
35. Federa	0	0
36. Other C	469,852	202,004
37. Other C	0	0
38. Total C	926,649	819,046
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	4,839,168
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	4,839,168
46.Total Li	926,649	5,658,214
47.Total Eq	1,221,213	736,458
48.Total Li	2,147,862	6,394,672

		Balance per Medicaid Trial Balance
1.	Gross F	6,634,504
2.	Discour	-282,006
	Subtota	6,352,498
4.	Day Ca	0
5.	Other C	0
6.	Therapy	780,076
7.	Oxygen	3,880
	Subtota	783,956
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	1,384
13.	Barber	15,689
14.	Non-P	8
15.	Teleph	40
16.	Rental	0
17.	Sale o	109,203
18.	Sale o	0
19.	Labora	10,935
20.	Radiol	2,806
21.	Other	96,603
22.	Laund	4,846
	Subtot	241,514
24.	Contril	0
25.	Interes	7,727
	Subtot	7,727
27.	Other	9,648
28.	Other	0
	Subtot	9,648
30.	Total F	7,395,343
31.	Gener	1,217,178
32.	Health	3,329,980
33.	Gener	1,386,670
34.	Owner	1,140,253
35.	Specia	120,891
35.	Provid	94,170
37.	Other	0
40.	Total E	7,289,142
41.	Incom	106,201
42.	Incom	0
43.	Net In	106,201

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Lexington Health Care C** **03:14 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-642,972	equal to	-642,972	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	343,095	equal to	343,095	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	117,699	equal to	117,699	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	229,039	equal to	229,039	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	505	equal to	505	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	472,734	equal to	472,734	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	87,283	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,217,178	equal to	1,217,178	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,329,980	equal to	3,329,980	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,386,670	equal to	1,386,670	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,140,253	equal to	1,140,253	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	120,891	equal to	120,891	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	94,170	equal to	94,170	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,934,615	equal to	2,054,358	-119,743	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	133,483	equal to	133,483	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	61,903	equal to	61,903	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	284,440	equal to	284,440	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	49,749	equal to	49,749	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	290,767	equal to	290,767	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	21,059	equal to	21,059	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	148,063	equal to	148,063	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	334,066	equal to	334,066	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,377,888	equal to	3,377,888	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,288	< or = to	9,288	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	398,798	< or = to	398,798	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,491	< or = to	2,491	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,475	< or = to	2,475	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		equal to	148,063	#VALUE!	#VALUE!	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	260,702	equal to	260,702	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	69,027	equal to	69,027	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	439,734	equal to	439,734	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	29,499	equal to	29,499	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,697	equal to	5,697	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	94,170	equal to	94,170	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,155	< or = to	45,011	-35,856	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,155	equal to	9,155	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,199	equal to	4,302	-103	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-622,572	equal to	-622,572	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	4,983,113	equal to	4,983,113	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	120,000	equal to	120,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	402,548	equal to	402,548	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,547,401	equal to	5,547,401	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	776,025	equal to	776,025	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,229,862	equal to	2,229,862	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,221,213	equal to	1,221,213	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	106,201	equal to	106,201	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	4,511	equal to	4,511	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,147,862	equal to	2,147,862	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1